## **HEALTH ACTION PLAN**

SECTION I. Demographic Information	
Member Name: Ka	anCare ID No.:
Address:	
Phone: Date of Birth:	Gender: Select
Primary Language:	Race: Select Select
SECTION II. Additional Contact Information	Select Female Male
Parent/Foster Parent/Legal Guardian:	Alaska Native American Indian
Address:	Asian
Medical Power of Attorney:	Black or African American Pacific Islander
Address:	White
	i none.
KanCare MCO: MCO Care Manager:	
Address:	Division
	Phone:
Health Home Partner:	
Health Home Care Coordinator:	
Address:	Phone:
Other Support Person:	
Address:	Phone:
SECTION III. Physical and Behavioral Health	<b>Y</b>
Substance Use Disorder Brief Screen:  Substance Use Disorder Assessment:  Results of Screening:  Drug(s) of Choice:  Medication/Reconciliation:  Select  Select  Yes  No	

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SECTION IV.	Existing	Plan (If appli	cable)			
Do you ha	Do you have an existing plan? Select Select					
Plan type: Select Yes						
SECTION V.	Select	Directives				
Advance	None Autism	s: Select	Select			
SECTION VI	FE IDD	d Steps to /	Yes No	vals must a	ddress needs and must have measurable outcome)	
Goal:	PD	J Steps to 7	140	vais illust at	duress fieeds and must have measurable outcome)	
Steps to	SED	al:				
	TA TBI					
Strength a	Strength and Needs:					
Measurab	da Outca	moi				
ivieasurau	ne Outco	ille.				
Start Date	):			Co	ompletion Date:	
Progress (	date):					
Goal:						
Steps to A	chieve G	ioal:				
Strength a	and Need	ds:				
Measurab	ile Outco	me:				
Start Date	<b>:</b> :			Co	ompletion Date:	
Progress (	date):					
0 1						
Goal: Steps to A	chieve G	inal:				
Steps to 7	icineve d	Jour.				
Strength a	and Need	ds:				
Measurab	Measurable Outcome:					
Start Date	Start Date: Completion Date:				ompletion Date:	
Progress (						
	Goal: Steps to Achieve Goal:					
Jieps to A	Steps to Achieve Goal:					
Strength a	Strength and Needs:					
Measurable Outcome:						
Start Date	tart Date: Completion Date:			ompletion Date:		
	Progress (date):					

## **HEALTH ACTION PLAN**

ECTION VII. Signa	tures	
Completed by:	Select Select	Date:
	Care Coordinator	
Completed by:	Select Case Manager Family Member Health Home Participant	Date:
Completed by:	Select	Date:
Completed by:	Select	Date:
Completed by:	Other:	Date:
	Describe Other:	